2005 Plan Comparison Chart

BASIC PROVISIONS

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Deductible (not included in coinsurance maximums)	n/a	Network n/a	Non-Network $500 single/$1,500 family	Network n/a	Non-Network $500 single/$1,500 family
Coinsurance 1	10%	Network 50%	Non-Network 50%	Network 50%	Non-Network 50%
Coinsurance Maximum 1 (does not include deductible or copayments)	$1,000 single/$2,000 family	Network $1,100 single/ $2,200 family	Non-Network $1,450 single/ $2,900 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family
Coinsurance 2	n/a	Network 30%	Non-Network 30%	Network n/a	Non-Network n/a
Coinsurance Maximum 2 (does not include deductible or copayments)	n/a	Network $1,100 single/ $2,200 family	Non-Network $2,200 single/ $4,400 family	Network n/a	Non-Network n/a
Total Coinsurance Maximum (does not include deductible or copayments)	$1,000 single/$2,000 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family
Copayment Summary - see specific category for detail on copayments.		Network	Non-Network	Network	Non-Network
Physician Office Visit	$20 PCP / $30 Specialist	n/a (Coins. applies)	n/a	n/a (Coins. applies)	n/a
Outpatient Mental Health (Not Biologically Based)	$25	$25	$25	$25	$25
Inpatient Services*	$200 per admission	$300 per admission	$600 per admission	$300 per admission	$600 per admission
Emergency Room Visit*	$75	$100	$200	$100	$200
Urgent Care Facility Visit	$30	n/a	n/a	n/a	n/a
Outpatient Surgery*	$100 per surgery	n/a	n/a	n/a	n/a
Major Diagnostic Tests*	$100 per test	n/a	n/a	n/a	n/a
Lifetime Benefit Maximum	$2,000,000 per person	$2,000,000 per person		$2,000,000 per person	
Primary Care Physician (PCP)	PCP manages and/or directs all care.	PCP not required.		PCP not required.	
Provider Choice	Local Network. Referrals required for care not by Primary Care Physician.	Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.		Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.	
Out of Network Care	Must be referred by PCP and pre-approved by Health Plan. Subject to coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
Out of Area Care	Covered only for initial treatment of medical emergency or if pre-approved by Health Plan. Subject to coinsurance and applicable copayments.	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
Amounts Above Plan Allowance	Provider to write off	Network Provider to write off	Non-Network Member responsibility	Network Provider to write off	Non-Network Member responsibility

* These copayments not included in coinsurance maximums. These services may require coinsurance.

2005 Plan Comparison Chart

COVERED SERVICES

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Inpatient Services	$200 copayment per admission, then subject to coinsurance. Copayment does not apply towards coinsurance maximum.	Network $300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Non-Network $600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum	Network $300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Non-Network $600 copayment per admission, then subject to coinsurance. Deductible does not apply.Copayments do not apply towards coinsurance maximum.
Outpatient Surgery	Subject to $100 copayment per surgery, then subject to coinsurance. Copayment does not apply to coinsurance maximum	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Ambulance Services	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Major Diagnostic Tests (includes but not limited to: PET Scans, CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography)	Must be pre-approved by Health Plan.Subject to $100 copayment per test then subject to coinsurance. Copayment does not apply to coinsurance maximum.	Must be pre-approved by Health Plan Network Subject to coinsurance	Non-Network Subject to ded & coins.	Must be pre-approved by Health Plan Network Subject to coinsurance	Non-Network Subject to ded & coins.
Other Outpatient Services	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physician Office Visits	Subject to office visit copayment. $20 for PCP, $30 for all other office visits. Copayments do not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physician Hospital Visits	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Emergency Room Visits	$75 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Network $100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Non-Network $200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Network $100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Non-Network $200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.
Urgent Care Facility Visits	$30 copay plus coinsurance. Copayment does not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Home Health Care	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Hospice	Services must be pre-approved by Health Plan. Limited to $7,500/ lifetime. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Network Subject to coinsurance	Non-Network Subject to ded. & coins.

2005 Plan Comparison Chart

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Surgery/Anesthesia/ Asst. Surgeon	Subject to applicable inpatient or outpatient copayments, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physical Rehabilitation Services (Including Chiropractic)	Services must be pre-approved by Health Plan. Inpatient limited to 60 days. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Office visit copay plus subject to coinsurance.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Durable Medical Equipment	Services must be pre-approved by Health Plan. Subject to coinsurance. Limited to $5,000 of covered services per person per year.	Services must be pre-approved by Health Plan. Limited to $4,500 of covered services per person per year. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $4,500 of covered services per person per year. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Allergy Testing	As approved by Primary Care Physician. Subject to $30 Specialist office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Antigen Administration (desensitization/treatment) - Allergy Shots	As approved by Primary Care Physician. Subject to applicable office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. Subject to $30 Specialist office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved and precertified by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved and precertified by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Childhood Immunizations to Age 6	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.		Covered at 100% as required by state mandate.	

MENTAL HEALTH

Inpatient Nervous & Mental/Drug & Alcohol	Subject to inpatient copayment, then subject to coinsurance Copayment does not apply towards coinsurance maximum. 60-day limit per year.	Network Subject to inpatience copayment, then subject to coinsurance. Copayments do not towards coinsurance maximum. 60-day limit per year.	Non-Network Subject to inpatience copayment, then subject to deductible and coinsurance. Copayments do not apply towards coinsurance maximum. 30-day limit per year.	Network Subject to inpatient copayment, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. 60-day limit per year.	Non-Nework Subject to inpatient copayment, then subject to deductible and coinsurance. Copayments do not apply towards coinsurance 30-day limit per year.
Outpatient Nervous & Mental/Drug & Alcohol	First 3 visits @ 100%, next 22 visits - $25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. Network First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	Non-Network First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.	Both in and out-of-network visits will be counted towards the first 25 visits. Network First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	Non-Network First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
Biologically Based Mental Health Conditions	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.		Benefits same as medical conditions for biologically based mental health conditions.	

2005 Plan Comparison Chart

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
ADULT PREVENTIVE CARE					
Preventive Care Services (One per calendar year for each service)	Must be provided by network providers. See specific categories below.	Network Preventive Care Allowance = 1st $300/person covered in full then subject to coinsurance.	Non-Network Not covered	Network Preventive Care Allowance = 1st $300/person covered in full then subject to coinsurance.	Non-Network Not covered
Well-Woman Care (office visit, PAP smear test, and STD testing as determined to be appropriate by the provider.)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostic tests covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Mammogram (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Must be provided by network providers. No referral required. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Well-Man Care (office visit, PSA blood test and STD testing)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostics covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Periodic Adult Physical Exam	Must be provided by PCP. Subject to $20 PCP office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive. Care Allowance then subject to coinsurance	Non-Network Not covered
Dietitian Consultation	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Routine Hearing Exam (Hearing aids NOT covered)	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Routine Vision Exam (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Age Appropriate Bone Density Screening	As approved by Primary Care Physician. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered
NON-COVERED SERVICES					
TMJ/Orthognathic Surgery	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental		Not Covered under Medical - see Dental	
Custom Shoe Inserts	Not Covered - see KanElect	Not Covered - see KanElect		Not Covered - see KanElect	
Gastric Surgery and Other **Weight Loss Treatments**	Not Covered - see KanElect	Not Covered - see KanElect		Not Covered - see KanElect	